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J. COLE MARSHALL.

SPLENECTOMY FOR ESSENTIAL PURPURA HÆMORRHAGICA.

(ESSENTIAL THROMBOCYTOPENIC PURPURA HÆMORRHAGICA.)

PURPURA is usually divided into (A) primary and (B) secondary. The primary is subdivided into (1) hæmorrhagic purpura (purpura simplex, purpura hæmorrhagica and purpura fulminans); and (2) anaphylactoid purpura (Henoch's purpura and Schönlein's purpura). In this article we are dealing only with essential purpura hæmorrhagica.

In essential purpura hæmorrhagica, in addition to the presence of purpuric spots on the skin and mucous membranes, there is bleeding from one or more mucous membranes, such as the nose, mouth, gums, urinary tract, uterus, intestinal tract, etc. It is the experience of most physicians who have investigated this disease that certain tests give with it positive results which clinch the diagnosis. These tests are: The presence of thrombocytopenia (the platelets being reduced at some period in the history of the case to 40,000 or less, and not infrequently none may be seen for a time); increased bleeding time from the normal 3 to 4 minutes to perhaps 15, 30 up to 60 minutes or even longer; and a positive capillary resistance test (*i.e.* if a pressure midway between the systolic and diastolic be maintained on the upper arm either by a rubber bandage or blood-pressure instrument for 3 minutes, hæmorrhagic areas appear, in positive cases, between the lower end of the bandage and the wrist). A flat-topped blood-clot has been described in this disease, but I do not think that this is of any real value, as many other diseases show the same thing.

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§

A SHORT REVIEW ON RECENT WORK, ESPECIALLY THE OPERATIONS FOR THE CURE OF DETACHMENT OF THE RETINA.

I HAVE chosen the above subject for my short paper, as I feel that everyone, whatever branch of medicine or surgery he may be practising, will be interested in the wonderful advance that has been made in the treatment and cure of the dread disease, detachment of the retina. It is only a few years ago that one practically had to say, " I am afraid there is no hope of a cure ".

In 1904 Prof. Marc Dufour, who was President of the Tenth International Congress of Ophthalmology, held at Lucerne, in his opening speech asked particularly if there would never be a " direct method of attaching the retina ", and he blessed in advance the man who would bring news of this nature to a future conference.

No doubt he would have felt great satisfaction in knowing that one day, in his own clinic, very encouraging observations would be made in the direction he was hoping. In fact, although retinal detachment had been known for fifty years, in its clinical manifestations, its treatment was no more advanced than in the first days of its examination with an ophthalmoscope.

The usual failures in attempting to cure the disease by lying in bed for weeks, with a compression bandage, by methods of producing copious sweating and subconjunctival injections, or more direct interventions, such as scleral punctures and draining the subretinal space, not without mentioning the more difficult injection of tincture of iodine into the vitreous, had given retinal detachment the reputation of being an incurable disease.

This reputation was hardly modified up till as late as 1929, and in spite of new methods which had been put into practice. Proof of this was to be found in all ophthalmic manuals, giving relapses—as a general rule—whatever treatment was applied.

Dr. Vail, in working out statistics in America, came to the conclusion that only about one case in a thousand was cured, and he therefore concluded that it would be as well to give up all slightly active treatment so long as no really curative method was known.

During the years 1904–1929 Prof. Gonin, of Lausanne, had been steadily working on the subject of the pathology of the retinal detachment, and had come to such definite conclusions as to a tear causing detachment of the retina that he actually performed a cautery puncture to close the tear as far back as 1916. He proved to his own satisfaction that the great majority of detached retinæ were due to holes occurring in the retina which allowed the vitreous, which was more fluid in this case, to enter into the tear and separate the retina from the choroid.

In spite of numerous papers which Gonin wrote, and although observers found the tear in a great number of detachments, not much notice was taken of his theory. Some authorities said the fact of the tear being present made the case hopeless as regards treatment; others said that the fluid must be removed and the retina re-attached irrespective of the tear. The author well remembers, when he visited Lausanne in 1930, the pride with which Gonin showed a beautiful specimen of an eye with a detachment where one could see the hole in the detachment, and the piece of the retina—the size of the tear—which was loose in the vitreous in the vicinity of the tear.

It was not till June, 1928, at the meeting of the Swiss Ophthalmological Society, that Gonin had the pleasure of hearing Prof. Vogt, of Zurich, and Prof. Sigrist, of Berne, confirm his results, which proved that closing of the tear in the retina cured the detachment. Since then Prof. Vogt has written a very fine monograph in the *Klinische Monatsblätter für Augenheilkunde*, which was published in 1929, and also another paper in 1930, which continued his series of cases, and added many important observations and cures; both these papers should be read by anyone interested in the early work on detached retina. Also, Prof. Arruga, of Barcelona, has published a very full paper with excellent drawings in the *Archivos de Oftalmologia*, October, 1929.

Gonin himself showed eight cured cases in Heidelberg at the German Ophthalmological Congress; this especially brought his work before all the well-known German surgeons. The result of all this work was the triumph of Gonin at the International Congress held at Amsterdam in 1929. At last his wonderful work was recognized and Dufour's wish was realized.

I have gone rather fully into the history of the early operative work of detachment of the retina, as one feels that whatever brilliant methods have since been evolved, Gonin stands out as the man who focused the eyes of the ophthalmological world on the possibility of operating and getting cures in detachment of the retina.

After the Ophthalmological Congress of 1929, surgeons all over the world began to do the operation. Sir William Lister and Mr. Goulden, of the Royal London Ophthalmic Hospital, introduced the operation into England in the latter part of 1929.

Though many cures were obtained, several surgeons felt that the method was associated with great dangers, such as a vitreous hæmorrhage, secondary tears and softening of the globe; also, the method needed very great care in the finding and exact marking of the tear.

This led to fresh methods being tried. First, there were the chemical methods of Guist, of Vienna, and also of Rubbrecht, of Bruges, the latter surgeon, though less known, doing some very careful work. Guist, after trephining and exposing the choroid, touched the choroidal tissue with caustic potash, finally perforating one of the many trephinings in order to let out the subretinal fluid. Lindner slightly modified and extended the method, writing a long monograph on the Lindner-Guist method. This method held sway for a short time, and was done most beautifully by Mr. Black, then Senior House Surgeon at Moorfields. There were many drawbacks to this method, the length of the operation and the many trephinings being liable to cause weakening of the sclerotic. The method used by Rubbrecht was the injection of jequiritol in various strengths. He claimed some successes, but to me the method seemed dangerous, as the reaction was very severe.

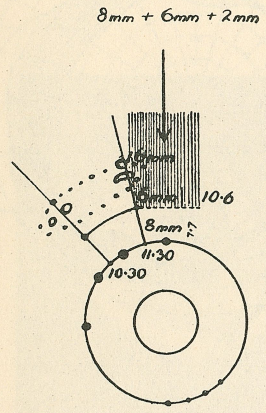
I feel one should also mention the wonderful amount of work done by Prof. Sourdille, of Nantes, who worked coincidentally with Gonin. Sourdille's conception of the causation of detachment of the retina was different from that of Gonin. He believed that degeneration started in the choroidal layer; subsequently fluid formed, which finally caused a rupture of the retinal layer. His treatment consisted of multiple punctures with a long, thin Graefe, the puncture going through the detached retina into the vitreous. At the entrance to the punctures he injected 1 : 1000 cyanide of mercury under the conjunctiva, this fluid causing an adhesive choroiditis. Sourdille also made use of fine electro-cautery needles, with which he made multiple punctures in the region of shallow detachments.

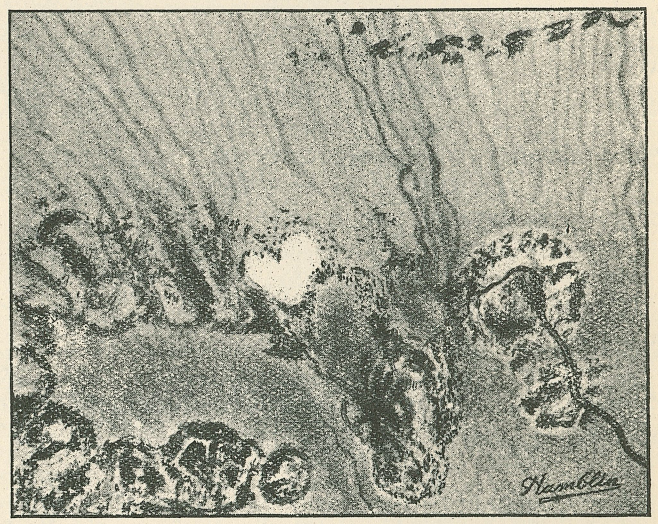
In 1932 Sven Larsson, of Sweden, wrote a paper on the treatment of detachment of the retina with diathermy. He used a small ball ·65 mm. in diameter; this was held against the sclerotic for five seconds with a weak current of about 50 milliamperes. This application caused small areas of coagulation in the choroid, which caused the retina to adhere. When the cauterizations were finished, a trephining was done to let out the subretinal fluid. Larsson claimed that his operation caused far less danger to the vitreous, and one could ignore the importance of the hole in the retina, as by the large areas of coagulation the whole detached retina could be made to adhere.

The next important communication was that of Prof. Weve, of Utretcht, who published a paper on the treatment of detachment of the retina by diathermy. He especially supported the work of Larsson, but went still further, and in some cases used a fine, straight needle, with which he made multiple punctures *into the sclerotic*, a third of its depth; if necessary he made a

further puncture with a larger diathermy needle to let out the subretinal fluid.

At the same time that Weve was working with his fine needle, multiple puncture operation, Dr. Safar, of Vienna, had patented a special instrument with several needles, 1½ mm. long, which are at right angles to the handle, with which he perforated the sclerotic and got areas of coagulation situated in the choroidal layer, these areas being about the size of the optic disc. In Safar's operation no trephining or subsequent punctures are made, as the needle punctures allow the subretinal fluid to come out and continue to drain into the subtenon capsular space. The special arrangement of the needles allows the operator to make punctures right back to the posterior pole of the globe.





Retina After Safar's Operation.

I propose now to give short accounts of two operations, first Gonin's, and then the operation perfected by Safar.

I have chosen these two operations because I feel they are the most important. Gonin was the first man to publish a large group of cured detached retina cases, and his technique has been very closely followed by all operators, whatever their method, the one exception being Larrson—who does not bother about the closing, or surrounding, of the tear.

Gonin's Operation.

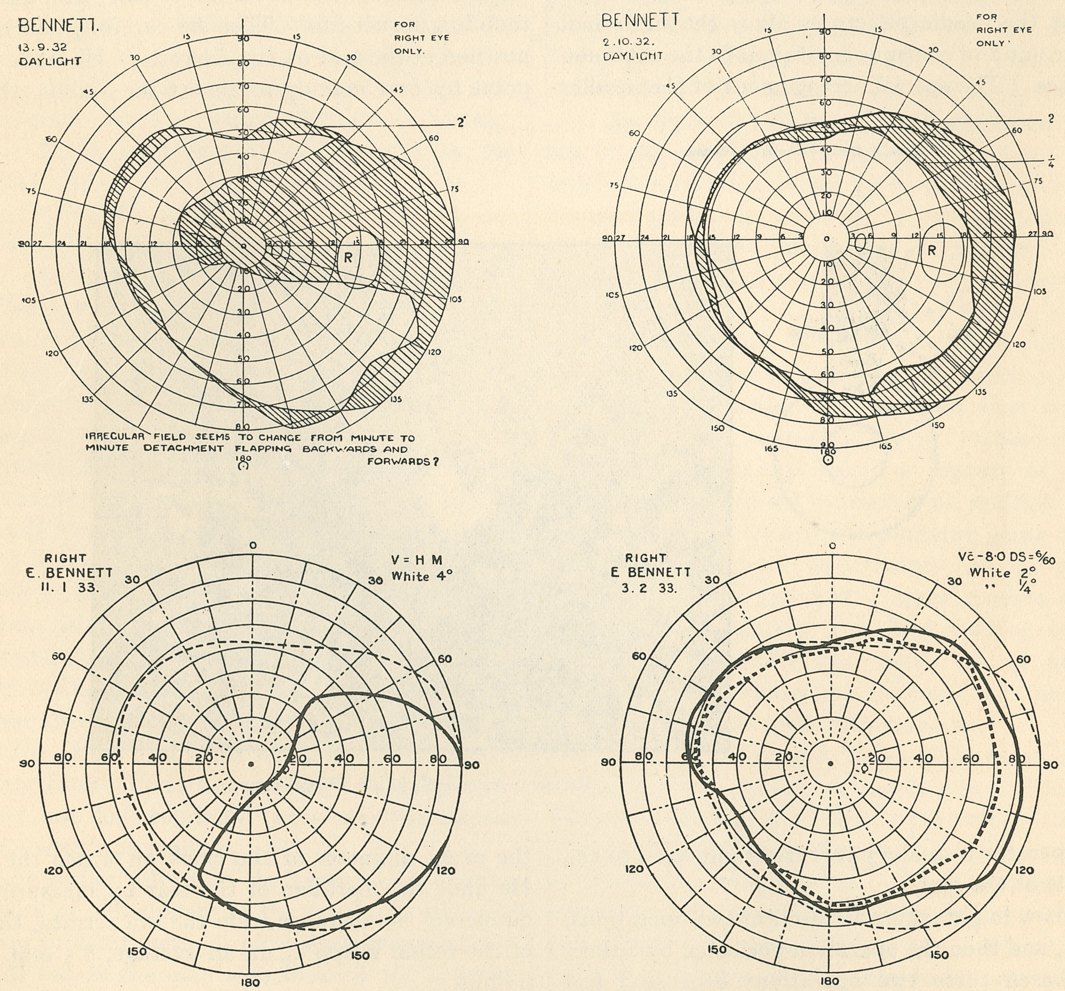
Gonin is especially keen on a very careful examination of the case as regards local symptoms, the field, or lack of field, of vision, any blind spot or local disturbances, such as floating objects, flashes of light, etc. All these points help to show in what region to look principally for the tear. Searching for the tear is a very important point. Gonin works in the various diameters of a clock-face, and notes different areas where there are pigmentary disturbances and fine, degenerative patches. In his papers Prof. Vogt especially laid stress on the importance of degenerative patches other than pigmented ones.

When the tear has been found Gonin makes most minute and careful sketches of the tear and its surrounding structures. Then he carefully marks out the position of the tear on the sclerotic. He leads up to this point by first making marks at the limbus, and getting the exact diameter of the clock on which the tear lies. He finds the meridian of the tear by measuring in disc diameters the distance from the ora serrata, the portion of the retina which is, on an average, 8·5 mm. from the limbus.

The final step is done after he has given a subconjunctival injection and made the field of operation quite anæsthetized. After making the necessary conjunctival incision and exposing the sclera, he plunges the cautery —at a white heat—through the sclerotic to the depth of about 4–5 mm. The cautery passes through the sclera, choroid and retina into the vitreous.

Immediately the cautery is taken out, he ties the suture, which he had previously placed on the edge of the conjunctival incision, and the patient is put back to bed in such a position that the vitreous presses on the situation of the tear. If no complications arise the eye is dressed on the third or fourth day after the operation and a very rough test is made with hand-movements. At the end of a week a further examination is made, and if the retina is back the patient is allowed to get up on the fourteenth day. If the case is not cured Gonin operates again in two or three weeks.

The following illustration shows a case cured by Gonin's method. The patient was admitted to the Western Ophthalmic Hospital on September 8th, 1932. He had first noticed that he could not see to read a paper with the right eye after playing tennis. His vision gradually became worse, until he could only see hand-movements; the field was greatly reduced in size. A tear was found to be situated under the internal rectus of the right eye, 14 mm. from the limbus. Fortunately it was possible to close the tear with one puncture, and the patient, who has $\frac{6}{12}$ vision and a full field, has been back at his work for over twelve months.

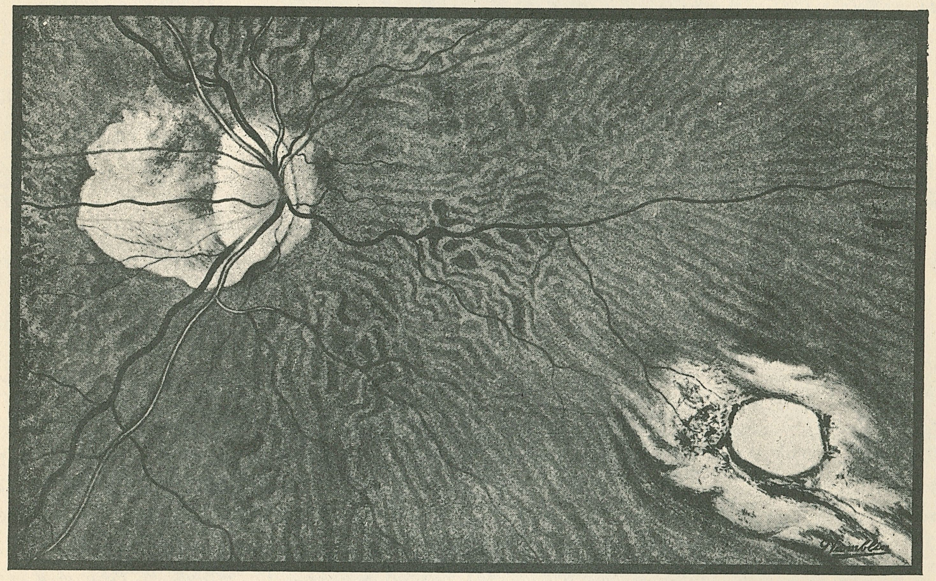


Visual Fields Before and After Safar's Operation.

Safar's Operation.

I now propose to describe the operation evolved by Safar, which, up to the present time, I consider to be the best surgical treatment for detachment of the retina. The method consists of making many punctures with a short, specially isolated needle, which is attached to the active pole of a special diathermy apparatus, with which one can work with a very low milliamperage. Safar's needles are about 1½ mm. long, and are at right angles to a carefully isolated handle, which is inserted into a holder attached to the diathermy machine by a long cable. It is important that whatever machine is used it should be so constructed that there is no sparking; the current can be regulated minutely and the milliamperage used easily seen. Safar uses many kinds of points, but a great deal can be done with the one-point needle. On the other hand, "nails" have been constructed with three points, 2 mm. apart, which can be inserted under current into the sclerotic, and left *in situ* until the required number of punctures has been made. By this method it is possible to keep the globe at a good tension. For tears more than 16 mm. from the limbus, either the one-point needle, or a special handle with round or oblong plates at the end, into which six or nine needle points are inserted, at right angles, can be used. If the latter is used it is important to draw it out "under current".

The first stages of Safar's operation are the same as Gonin's, except that it is not so important actually to mark the exact site of the tear, as this can be encircled by the multiple punctures; or a tear within 16 mm. of the ora serrata can be partially encircled with punctures, the base of the semicircle resting on the ora serrata line. An important point is to get the sclera very clean and free from subtenon capsular adhesions. If necessary muscles can be resected in order to get large areas exposed; half, or more, of the circumference of the globe can be laid bare without danger, though it is best to avoid resecting more than two muscles.



Retina One Month After Safar's Operation.

With Safar's method there is no restriction to the treatment of tears, however far back they may be situated, but when the tear is posterior the position of the venæ vorticosæ veins must be remembered and avoided; the punctures should be made posteriorly to where they make their exit from the sclera, and also at the sides of the point of exit, and not right through the sclerotic. When making the punctures it is important to place the point of the needle in the sclera before applying the current.

The punctures should be posterior to, or free of, the margin of the tear or "disinsertion" tears treated. This enables the healthy, untouched retina to adhere to the areas of coagulation which are situated in the choroidal layer.

The most important points of Safar's technique are that he does not injure the retina or enter the vitreous, and that the subretinal fluid drains off slowly and continually through the diathermy punctures, thus doing away with the trephinings or punctures which are necessary in Larsson's method. These trephinings, etc., may cause a "hernia of the choroidal tissue" and, eventually, dragging on the retina and subsequent retinal bands or fresh tears may be formed. The scars formed with Safar's method are so placed that retinal vessels can be seen passing flatly over them.

To obtain successful results one should try to keep the patient in bed for at least three weeks, and, if possible, the patient should lead a very quiet life and lie up as much as possible for another five weeks. Also, after the first fortnight it is beneficial for the patient to use a special pair of dark spectacles, made of celluloid, with a hole 5 mm. in diameter in the centre; these are called Lochbrille glasses. An efficient glass of this kind can be made by putting dark paper, with a central opening, on an ordinary pair of spectacles.

The illustrations show a successful operation carried out according to this technique. The holes were marked out and surrounded by 16 to 20 diathermy punctures. The man, a tailor, æt. 58, only saw daylight on January 5th, 1933. After the operation he saw $\frac{6}{18}$ with his proper correction. On November 3rd, after working at his trade since March, he saw $\frac{6}{18}$. The area of the punctures is now much whiter and less injected than in the illustration, which was done a month after the operation.

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The British Journal of Surgery—The Nursing Times—Charing Cross Hospital Gazette—Guy's Hospital Gazette—Magazine of the London Royal Free Hospital—Middlesex Hospital Journal—St. Mary's Hospital Gazette—St. Thomas's Hospital Gazette—The Student—University College Hospital Magazine—King's College Gazette—University of Toronto Medical Society Magazine—Clinical Journal—East African Medical Journal—The General Practitioner—The Hospital—Bulletins et Mémoires de la Société Médecine de Paris—L Echo Médicale du Nord—The Medical Forum—The Medical Press and Circular—Medical Times and Long Island Medical Journal—Post-graduate Medical Journal—Reale Società Italiana D'Igiene—Revue Belge des Sciences Medicales—Archives Hospitalières.

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A SHORT REVIEW ON RECENT WORK, ESPECIALLY THE OPERATIONS FOR THE CURE OF DETACHMENT OF THE RETINA.

I HAVE chosen the above subject for my short paper, as I feel that everyone, whatever branch of medicine or surgery he may be practising, will be interested in the wonderful advance that has been made in the treatment and cure of the dread disease, detachment of the retina. It is only a few years ago that one practically had to say, " I am afraid there is no hope of a cure ".

In 1904 Prof. Marc Dufour, who was President of the Tenth International Congress of Ophthalmology, held at Lucerne, in his opening speech asked particularly if there would never be a " direct method of attaching the retina ", and he blessed in advance the man who would bring news of this nature to a future conference.

No doubt he would have felt great satisfaction in knowing that one day, in his own clinic, very encouraging observations would be made in the direction he was hoping. In fact, although retinal detachment had been known for fifty years, in its clinical manifestations, its treatment was no more advanced than in the first days of its examination with an ophthalmoscope.

The usual failures in attempting to cure the disease by lying in bed for weeks, with a compression bandage, by methods of producing copious sweating and subconjunctival injections, or more direct interventions, such as scleral punctures and draining the subretinal space, not without mentioning the more difficult injection of tincture of iodine into the vitreous, had given retinal detachment the reputation of being an incurable disease.

This reputation was hardly modified up till as late as 1929, and in spite of new methods which had been put into practice. Proof of this was to be found in all ophthalmic manuals, giving relapses—as a general rule—whatever treatment was applied.

Dr. Vail, in working out statistics in America, came to the conclusion that only about one case in a thousand was cured, and he therefore concluded that it would be as well to give up all slightly active treatment so long as no really curative method was known.

During the years 1904–1929 Prof. Gonin, of Lausanne, had been steadily working on the subject of the pathology of the retinal detachment, and had come to such definite conclusions as to a tear causing detachment of the retina that he actually performed a cautery puncture to close the tear as far back as 1916. He proved to his own satisfaction that the great majority of detached retinæ were due to holes occurring in the retina which